CHILD CARE CENTERS

RECORDKEEPING ESSENTIALS

of the

CHILD AND ADULT CARE FOOD PROGRAM

August 2005

Missouri Department of Health and Senior Services
Division of Community and Public Health
Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102

http://www.dhss.mo.gov/cacfp

Child Care Centers
Recordkeeping Essentials of the
Child and Adult Care Food Program

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Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services, Unit of Community Food and Nutrition Assistance, P.O. Box 570, Jefferson City, MO 65102, 1-800-733-6251. TDD users can access the preceding number by calling 1-800-735-2966.

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Recordkeeping Requirements for
Child Care Centers

Child care centers receiving payment from the Child and Adult Care Food Program (CACFP) must keep full and accurate records pertaining to the food service. The records must be kept to support the claim for reimbursement and to verify that all CACFP requirements are being met. The records to be maintained are detailed below.

All records must be retained for a period of three years after the end of the fiscal year to which they pertain, except that if audit findings have not been resolved, the records shall be retained beyond the end of the three-year period for as long as required for the resolution of the issues raised by the audit. All required records must be available for review by federal or state officials at all times. Failure to produce required records in a timely manner could result in re-payment to the Missouri Department of Health and Senior Services – Community Food and Nutrition Assistance (MDHSS-CFNA).

Sample forms and completion instructions for each record detailed below are included in this booklet. The institution may use these sample forms or other forms developed by the institution as long as the forms used record the required information.

Required records include:

1. **Copies of all menus.** Menus must be dated for each month and indicate all components that were served. Write in all substitutions. Menus must be maintained for each meal claimed for reimbursement. See page 5 and 7 for sample menu forms.

   For infants 0 through 11 months old, a separate menu, (individual infant meal record) is required.

   For infants 0 through 3 months, list the actual amounts for formula or breastmilk consumed as well as the time of feeding. Indicate which meals are being claimed (breakfast, a.m. snack, lunch, p.m. snack, supper, or evening snack). A maximum of 3 meals may be claimed regardless of the number of times the infant eats. See page 9 for a sample menu form for an infant 0 through 3 months of age.

   For infants 4 through 7 months old, circle the foods offered at each meal. The required amounts are listed on this form. It is not required to list the actual amount consumed for this age group. See Page 11 for a sample menu form for an infant 4 through 7 months of age.

   For infants 8 through 11 months old, list the actual foods offered. The required amounts are listed on this form. It is not required to list the actual amount consumed for this age group See page 13 for a sample menu form for infants 8 through 11 months of age.

Infant Feeding Preference. Centers that claim meal reimbursement for infants in their care are required to have this form completed and signed by parents of all infants enrolled. Keep this form with each infant's enrollment record. The purpose of this form is to obtain the parents' preferences and to determine if the infants' meals can be claimed for reimbursement. Centers must offer an iron-fortified infant formula that meets the needs of the majority of infants in care. Parents/guardians not wanting their infants to receive the center offered formula may bring infant formula or breast milk from home. However, if the center wishes to claim the infant's meals, the center must provide all other required meal components as appropriate for age according to the Infant Food Chart. See the Policy and Procedure Manual for Child Care Centers, Sections5.11 and 7.2 for more information on infant meal requirements. See page 15 of this booklet for an infant feeding preference form.

2. **Enrollment documents for each child claimed.** All children claimed for reimbursement must be enrolled at the center for care. Enrollment documentation must be obtained by the provider before any meals can be claimed for a child. Child enrollment forms are available from the Bureau of Child Care.

Centers are also encouraged to maintain a master listing to include:

a. all enrolled children

b. the claiming category for each child

c. the date the Income Eligibility Form (IEF) was signed by center personnel.

Use of the master listing will assist in keeping the IEFs updated on an annual basis. A sample form is included on page 17.

4. **Daily attendance records.** Daily attendance records must be maintained for each child. The attendance records **cannot** be used as a basis for completing the meal count record. However, the attendance records must support the meal count records. For example, if John Doe was claimed for a meal on October 17, the attendance records must indicate that John Doe was present on October 17.

   For the CACFP, you must choose one of these methods for your attendance record:
   - Time In/Time Out Record (Option A or B) (see pages 19 and 21)
   - Attendance Record (see page 23)

5. **Meal count records.** Each monthly claim for reimbursement must be supported by meal count records for each meal served during the month. The meal count record must indicate the meals served to each child by type of meal (breakfast, lunch, supper, or snack). Center personnel must physically record at each meal, the meals served to children by eligibility category (free, reduced, and paid). A maximum of

two meals and one snack or one meal and two snacks may be claimed per child per day. A sample form is included on page 25 of this booklet.

6. **Non-profit food service verification.** All centers must have documentation to verify that all of the CACFP reimbursement is being used solely for the conduct of the food service operation or to improve food service operations. Non-profit food service verification includes:

    a. Documentation of income to the program. Income to the program includes all monies received from State, Federal, or local government sources, any center funds used to subsidize the food service program, any payments for adult meals, and any other income including loans and donations to the food program.

    b. Documentation of food purchases. All monthly **food purchase records/receipts** must be maintained to support claims for reimbursement and to document non-profit food service operations. Food receipts will be closely examined to assure that foods purchased match menus for the time-period and to assess the quantity of food purchased. If it is determined that inadequate quantities of food were purchased to meet minimum meal pattern requirements, then meals will be disallowed. For this reason, it is very important that all food receipts are maintained in a central location. Receipts must be dated, itemized, and legible. Do not purchase food from companies that do not provide itemized, dated receipts.

    c. Documentation of other food service expenditures. Food service expenditures include labor cost **supported by payroll stubs and time studies**, cost of expendable food service equipment, cost of maintaining non-expendable food service equipment, and indirect costs. A form for documenting food service labor cost is included on page 27 of this booklet.

    Expendable equipment has a durability of less than two years with a cost of $500 or less. **Non-expendable equipment** has a durability of two years or more and cost more than $500. Examples of indirect costs are rent, utilities, office supplies, etc. A portion of indirect costs can be charged to the CACFP if there is documentation available to support the charge.

7. **Income Eligibility Forms (IEFs).** An IEF must be on file for each child claimed as free or reduced. IEFs must be updated annually. The IEF is effective for one year from the date the center representative signs and dates the form. See the Income Eligibility Guidance booklet for more information on proper completion of the IEF.

8. **Title XX documentation.** Title XX documentation must be available for for-profit centers. Title XX documentation includes the Department of Social Services - Division of Family Services (DFS) vendor invoices and a copy of the contract with

DFS for vendor children. For each month claimed, the center must have verification that at least 25% of license capacity or enrolled children (whichever is less) were Title XX beneficiaries.

9. **Documentation of training to staff.** The institution must ensure that staff is trained at least annually on CACFP issues. Documentation of training must include:

    a. session dates
    b. locations
    c. topics
    d. names of participants
    e. name of presenter

    A sample form is included on page 31.

10. **Beneficiary data form.** To meet Civil Rights requirements, each center must physically count, at least once per year, the number of program participants in attendance by racial/ethnic category. Documentation of this count must be maintained on file. Use the form included on page 33 of this booklet.

11. **Food substitution for medical reasons.** Participants with medical or special dietary needs may have substitutions to the meal pattern only when supporting documentation is on file. The documentation must be signed by a recognized medical authority such as a physician, physician assistant, nurse practitioner, or advanced practice nurse. See Policy 7.5 for more information. Use the form included on page 35 of this booklet.

12. **Miscellaneous documentation.** The following miscellaneous documentation must be retained:

    a. Child care center license.

    b. Copies of all applications and supporting documents submitted to the MDHSS-CFNA.

    c. Copies of all claims for reimbursement submitted to the MDHSS-CFNA. Claims forms are included in your claims packet each year. Always use the form for the correct fiscal year.

    d. Copies of all correspondence from MDHSS-CFNA or to MDHSS-CFNA.

    e. Copy of CACFP Policy and Procedure Manual with all annual updated policies.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

MENU – USDA REQUIREMENTS

NAME OF CENTER/FACILITY _____ WEEK OF _____ YEAR _____

BREAKFAST	DATE	DATE	DATE	DATE	DATE
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Other Foods					
SUPPLEMENT *Serve 2 of 4 choices.*					
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					
LUNCH					
Fluid Milk					
2 Servings of Fruit and/or Vegetables					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

MENU – USDA REQUIREMENTS

NAME OF CENTER/FACILITY _____ WEEK OF _____ YEAR _____

SUPPLEMENT *Serve 2 of 4 choices.*	DATE	DATE	DATE	DATE	DATE
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					
SUPPER					
Fluid Milk					
2 Servings of Fruit and/or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					
SUPPLEMENT *Serve 2 of 4 choices.*					
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INDIVIDUAL INFANT MEAL RECORD

0 THROUGH 3 MONTHS

INFANT'S NAME	MEALS CLAIMED ☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper	AGE (MONTHS)	DATE OF BIRTH
CENTER/PROVIDER	BREASTMILK ☐ YES ☐ NO	FORMULA TYPE	CLAIM MONTH/YEAR

CLAIM ONLY APPROVED MEALS

REQUIREMENTS	DATE		DATE		DATE		DATE		DATE	
	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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INDIVIDUAL INFANT MEAL RECORD

4 THROUGH 7 MONTHS

INFANT'S NAME		AGE (MONTHS)	DATE OF BIRTH
CENTER/PROVIDER	BREASTMILK ☐ YES ☐ NO	FORMULA TYPE	MONTH/YEAR

CLAIM ONLY APPROVED MEALS

REQUIREMENTS		DATE	DATE	DATE	DATE	DATE
		Circle or list specific foods consumed by this infant				
BREAKFAST Breastmilk or Iron Fortified Infant Formula	4-8 fl. oz.	Breastmilk Formula Rice cereal Barley Oatmeal Mixed cereal	Breastmilk Formula Rice cereal Barley Oatmeal Mixed cereal	Breastmilk Formula Rice cereal Barley Oatmeal Mixed cereal	Breastmilk Formula Rice cereal Barley Oatmeal Mixed cereal	Breastmilk Formula Rice cereal Barley Oatmeal Mixed cereal
Iron Fortified Dry Infant Cereal (when ready)	0-3 Tbsp.					
AM SNACK Breastmilk or Iron Fortified Infant Formula	4-6 fl. oz.	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula
LUNCH Breastmilk or Iron Fortified Infant Formula	4-8 fl. oz.	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg
Iron Fortified Infant Cereal (when readyl)	0-3 Tbsp.					
Fruit and/or Vegetable (not juice) (when readyl)	0-3 Tbsp.					
PM SNACK Breastmilk or Iron Fortified Infant Formula	4-6 fl. oz.	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula
SUPPER Breastmilk or Iron Fortified Infant Formula	4-8 fl. oz.	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:	Breastmilk Prunes Formula Apricots Rice cereal Carrots Barley Grn. Beans Oatmeal Peas Mixed cer. Potatoes Apples Sweet pot. Bananas Squash Peaches Spinach Pears Mixed veg Other:
Iron Fortified Infant Cereal (when ready)	0-3 Tbsp.					
Fruit or Vegetable (not juice) (when ready)	0-3 Tbsp.					

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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INDIVIDUAL INFANT MEAL RECORD

8 THROUGH 11 MONTHS

INFANT'S NAME		AGE (MONTHS)	DATE OF BIRTH
CENTER/PROVIDER	BREASTMILK ☐ YES ☐	FORMULA TYPE	MONTH/YEAR

CLAIM ONLY APPROVED MEALS

List specific foods consumed by this infant. Foods from child menu may be used if infant is developmentally ready

REQUIREMENTS	8-11 MO	Date	Date	Date	Date	Date
BREAKFAST						
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.					
Iron Fortified Infant Cereal	2-4 Tbsp.					
Fruit and/or Vegetable (not juice)	1-4 Tbsp.					
AM SNACK						
Iron Fortified Infant Formula[1] or Breastmilk or Full Strength Fruit Juice	2-4 fl. oz.					
Crusty Bread (optional)	0-1/2 slice					
Crackers (optional)	0-2					
LUNCH						
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.					
Iron Fortified Infant Cereal and/or	2-4 Tbsp.					
Meat, Fish, Poultry, Egg Yolk, or Cooked Dry Beans or Peas or Cheese or Cottage Cheese, Cheese Food or Spread	1-4 Tbsp. 1-4 Tbsp. 1/2 - 2 oz. 1-4 oz.					
Fruit or Vegetable (not juice)	1-4 Tbsp.					
PM SNACK						
Iron Fortified Infant Formula or Breastmilk or Full Strength Fruit Juice	2-4 fl. oz.					
Crusty Bread (optional)	0-1/2 slice					
Crackers (optional)	0-2					
SUPPER						
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.					
Iron Fortified Infant Cereal and/or	2-4 Tbsp.					
Meat, Fish, Poultry, Egg Yolk, or Cooked Dry Beans or Peas or Cheese or Cottage Cheese, Cheese Food or Spread	1-4 Tbsp. 1-4 Tbsp. 1/2 - 2 oz. 1-4 oz.					
Fruit or Vegetable (not juice)	1-4 Tbsp.					

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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CHILD AND ADULT CARE FOOD PROGRAM

INFANT FEEDING PREFERENCE – CENTERS

Name of infant _____ Date of Birth_____

_____ will feed your infant breastmilk provided by you and / or we
(name of provider)
will provide iron fortified infant formula.

The formula we provide is: _____

Please mark your preference (choose all that apply)	Date_____ Birth – 3 months	Date_____ 4 – 7 months	Date_____ 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

This center is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Date_____ 4 – 7 months	Date_____ 8 – 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid food for my infant when he / she is ready for it.		

First Signature of Parent / Guardian _____Date_____

Second Signature of Parent / Guardian _____Date_____

Third Signature of Parent / Guardian _____ Date_____

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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ENROLLMENT ROSTER

NAME OF CENTER/FACILITY _____ Page _____ of _____

NO.	PARTICIPANT'S NAME	FREE	REDUCED	PAID	DATE ENROLLED	DATE INCOME STATEMENT SIGNED	DATE TERMINATED

Instructions for Completing
Enrollment Roster

The enrollment roster is not a required record, however, will assist the center in tracking new enrollments and eligibility categories. The enrollment roster should be completed on an annual basis. Any new enrollees throughout the year can be added to the bottom of the list.

1. List all children enrolled at the center for child care (preferably in alphabetical order with last name, first name).

2. Indicate the child's claiming category (free, reduced, or paid).

3. Indicate the date when the child was enrolled.

4. Indicate the date when the IEF was signed by the center personnel.

5. Indicate the date when the child was terminated from the child care facility.

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TIME IN/TIME OUT RECORD

DAY OF WEEK _____ DATE _____

NAME (last, first alphabetically)	TIME IN	INITIALS	TIME OUT	INITIALS	HOURS ATTENDED

Instructions for Completing Time In/Time Out Record
Option A

Option A uses one page for each day. All children's names are on the same page/pages listed alphabetically by last name.

1. Enter day of the week.

2. Enter calendar date indicating month, day, and year.

3. List the enrolled children (in alphabetical order with last name first).

4. Indicate in the "time in column" the time the child arrives at the child care center and the initials of the person who enters the time.

5. Indicate the time the child leaves the child care center and the initials of the person who enters the time.

6. Total the number of hours attended each day.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
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MONTHLY ATTENDANCE TIME IN/TIME OUT RECORD

CHILD'S NAME _____ **MONTH** _____ **YEAR** _____

	MONDAY		**TUESDAY**		**WEDNESDAY**		**THURSDAY**		**FRIDAY**	
WEEK OF	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
WEEK OF	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
WEEK OF	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
WEEK OF	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
WEEK OF	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										

Instructions for Completing Time In/Time Out Record
Option B

Option B uses one page for each child. Sheets are kept in a three ring binder notebook. New names can be added and old names removed as necessary. Each letter of the alphabet or each family name has its own tab making it easier to locate.

1. Enter the month and year.

2. Enter the child's name.

3. Enter the date of the week.

4. Enter the time the child arrives at the child care center.

5. Enter the time the child leaves the child care center.

6. Total the number of hours attended each day.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

MONTH: _____

DAILY ATTENDANCE RECORD

Participant's Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
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MEAL COUNT

CENTER	WEEK OF	**KEY**
		B-Breakfast, 1-1st Snack, L-Lunch, 2-2nd Snack, D-Dinner

PARTICIPANT'S NAME	**CODE**	**MONDAY** DATE					**TUESDAY** DATE					**WEDNESDAY** DATE					**THURSDAY** DATE					**FRIDAY** DATE					**TOTALS**				
		B	1	L	2	D	B	1	L	2	D	B	1	L	2	D	B	1	L	2	D	B	1	L	2	D	B	1	L	2	D
Total Meals Coded **X**																														
Total Meals Coded **Y**																														
Total Meals Coded **Z**																														

Instructions for Completing
Meal Count Form

The meal count must be recorded at the time of the meal service. Center personnel must physically count the children eating at each mealtime. The claiming categories for each child must be kept confidential.

1. Enter the calendar date, showing month, day, and year in appropriate spaces.

2. List enrolled children (preferably in alphabetical order with last name, first name).

3. For each child, indicate claiming category under the code box using the following codes:

   X: Free category
   Y: Reduced category
   Z: Paid category

4. For each meal served, place a check mark under the appropriate meal type.

5. Calculate the total free meals, total reduced meals, and total paid meals for each meal category, across and down. Compare the across calculations with the down calculations to check for accuracy.

6. Meal Count Forms for seven-day operations are available upon request, by calling 800-733-6251.

Instructions for Documenting
Non-Profit Food Service

1. Save all food receipts and invoices. Nonfood expenditures can be charged to the food service if the nonfood product is necessary to the food service. Examples of allowable nonfood charges include paper napkins, straws, plastic utensils, cleaning supplies for the kitchen, etc.

   Only those foods used for the CACFP can be charged to the food service. Food items such as coffee cannot be counted toward the CACFP food service costs.

2. Determine the total amount of food and nonfood costs. If this amount is less than the CACFP monthly reimbursement, document food service labor costs. If the amount of food cost for the month is greater than the CACFP reimbursement, the center does not need to document labor costs.

3. Determine the amount of labor spent on the food service. The attached form "Summary of Salary Expenses" will assist in determining how much labor cost can be charged to the food service. Each position used for the food service shall be listed. For each position, indicate:

   a. The number of people in the position;

   b. The salary per hour;

   c. The number of hours spent on the food service; and

   d. The total cost chargeable to the food program.

   Labor cost charges must be supported by payroll stubs and time studies.

4. Determine the amount of income for the food program. Income to the food program can include monies received from state, federal, or local government sources, any center funds used to subsidize the food program, any payments for children's or adult's meals, and donations of food, supplies, equipment, or cash to the food program.

5. Add together the food costs, nonfood costs, and labor costs. Compare this amount to the monthly CACFP reimbursement plus income to the program. If the CACFP reimbursement and income are greater than food service costs, contact MDHSS-CFNA for further instructions.

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SUMMARY OF SALARY EXPENSES

FACILITY NAME							CLAIM MONTH
POSITION TITLE	**SALARY PER HOUR**	**X**	**HOURS WORKED PER DAY ON FOOD SERVICE**	**X**	**DAYS WORKED PER MONTH**	**=**	**TOTAL**
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
		X		**X**		**=**	
					TOTALS	**=**	

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TRAINING DOCUMENTATION

DATE	TIME

TRAINING SITE

TRAINER NAME	TITLE / POSITION

TOPIC(S) PRESENTED: (CHECK ALL THAT APPLY.)

- ☐ Meal/Snack Requirements
- ☐ Menus
- ☐ Meal Count Procedures
- ☐ Other_____
- ☐ Other_____
- ☐ Daily Attendance Records
- ☐ Creditable Foods
- ☐ Child Nutrition
- ☐ Fostering Healthy Eating Habits
- ☐ Other_____

Attendance Sign-In

Name *(please sign)*	Title/Position

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COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

BENEFICIARY DATA REPORT

A Beneficiary Data Report must be completed once a year to report the racial/ethnic category of participants enrolled in your center. Determine the participant's racial/ethnic category visually using your best judgement. A participant may be included in the category to which he or she appears to belong, identifies with, or is regarded as a member of by the community.

NAME OF CENTER/FACILITY:

ADDRESS:

Racial/Ethnic Category	Number of Participants
Alaskan Native or Native American – A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition (includes Aleuts and Eskimos).	
Asian or Pacific Islander – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.	
Black (not of Hispanic origin) – A person having origins in black racial groups of Africa.	
Hispanic – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.	
White (not of Hispanic origin) – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.	
SIGNATURE OF DIRECTOR ▶	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
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MEDICAL FOOD SUBSTITUTION RECORD

The Child & Adult Care Food Program Requirements for Meal Pattern Substitutions Section 7.5 require food substitutions to be authorized by a recognized medical authority. Recognized medical authority includes physician, physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the child's diet and the food or choice of foods that may be substituted.

CHILD'S NAME:

MEDICAL DIAGNOSIS / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

FOOD SUBSTITUTION LIST:

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternative (e.g., eggs, cheese peanut butter, dry bean, yogurt, etc.)	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Bread, Cereal or Whole Grain Products	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Fruit & Vegetables or Juice	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)

Additional Dietary Concerns and/or Required Equipment or Assistance Needed:

I (medical authority) certify that the above child must be provided a special diet or requires special accommodations as indicated above.

SIGNATURE	TITLE	DATE